HCFA-1450

3604. REVIEW OF FORM HCFA-1450 FOR INPATIENT AND OUTPATIENT BILLS

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on the HCFA-1450 are described, but detailed information is given only for items required for Medicare claims. The National Uniform Billing Committee (NUBC) maintains a complete list of allowable data elements and codes. You must be able to capture all NUBC-approved input data for audit trail purposes and be able to pass all data to other payers with whom you have a coordination of benefits agreement. Items listed as "Not Required" need not be reviewed although providers may complete them when billing multiple payers. All Medicare claims you process must be billed on the HCFA-1450 billing form or billed using related electronic billing record formats.

If required data is omitted, obtain it from the provider or other sources and maintain it on your history record. It is not necessary to search paper files to annotate missing data unless you do not have an electronic history record. You need not obtain data not needed to process the bill.

Data elements in the HCFA uniform electronic billing specifications are consistent with the HCFA-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system for both the HCFA-1450 and the electronic specifications are identical.

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit - Type of Facility
1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Non- Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special Facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit - Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients", and referred diagnostic services).
5 - Intermediate Care - Level I
6 - Intermediate Care - Level II
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement.)
9 - Reserved for National Assignment

2nd Digit - Classification (Clinics Only)
1 - Rural Health Clinic (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free-Standing Provider-Based Federally Qualified Health Centers (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit - Classification (Special Facilities Only)
1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6-8 Reserved for National Assignment
9 - OTHER

3rd Digit - Frequency	Definition
A - Hospice Admission Notice	This code is used when the hospice is submitting the HCFA-1450 as an admission notice.
B - Hospice Termination/ Revocation Notice	This code is used when the hospice is submitting the HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.

C - Hospice Change of Provider Notice	This code is used when the HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/Cancel	This code is used when the HCFA-1450 is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	This code is used when the HCFA-1450 is used as a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	This code is used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	This code is used to identify adjustments initiated by CWF. For intermediary use only.
H - HCFA Initiated Adjustment Claim	This code is used to identify adjustments initiated by HCFA. For intermediary use only.
I - Int. Adjustment Claim (Other Than PRO or Provider)	This code is used to identify adjustments initiated by you. For intermediary use only.
J - Initiated Adjustment Claim-Other	This code is used to identify adjustments initiated by other entities. For intermediary use only.
K - OIG Initiated Adjustment Claim	This code is used to identify adjustments initiated by OIG. For intermediary use only.
M - MSP Initiated Adjustment Claim	This code is used to identify adjustments initiated by MSP. For Intermediary use only. Note: MSP takes precedence over other adjustment sources.
P - PRO Adjustment Claim	This code is used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
0 - Nonpayment/zero claims	This code is used when the provider does not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to the provider.
1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2 - Interim - First Claim	This code is used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment.

3 - Interim - Continuing Claims (Not valid for PPS Bills)	This code is used when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4 - Interim - Last Claim (Not valid for PPS bills)	This code is used for a bill for which utilization is chargeable and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this confinement or course of treatment.
5 - Late Charge Only	This code is used only for outpatient claims. Late charge bills are not accepted for Medicare inpatient or ASC claims.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or new bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also submitted by the provider showing corrected information.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period included on this bill are shown in numeric fields (MM-DD-YY). Days before the patient's entitlement are not shown. Use the "From" date to determine timely filing. (See §§3307ff.)

FL 7. Covered Days
Required. The total number of covered days during the billing period applicable to the cost report including lifetime reserve days elected for which Medicare payment is requested, is entered. This should be the total of accommodation units reported in FL 46. Covered days exclude any days classified as noncovered, as defined in FL 8, leave of absence days, and the day of discharge or death.

If you made an adverse coverage decision, enter the number of covered days through the last date for which program payment can be made. If waiver of liability provisions apply, see §344l.

The provider does not deduct any days for payment made in the following instances:

- o WC;
- o Automobile medical, no-fault, liability insurance;
- o An EGHP for an ESRD beneficiary;
- o Employed beneficiaries and spouses age 65 or over; or
- o An LGHP for disabled beneficiaries.

Enter the number of days shown in this FL in the cost report days field on the UB-92 CWF RECORD. However, when the other insurer has paid in full (see §§3682, and 3685), enter zero days in utilization days on the UB-92 CWF RECORD. For MSP cases only, calculate utilization based upon the amount Medicare will pay and enter the utilization days chargeable to the beneficiary in the utilization days on the UB-92 CWF RECORD. (See §§3682 and 3685.)

For discussion of how to determine whether part of a day is covered, see §§3620ff.

If the provider reported an incorrect number of days, report the correct number when you submit the CWF RECORD.

FL 8. Noncovered Days
Required. The total number of noncovered days during the billing period within the "From" and "Through" date that are not claimable as Medicare patient days on the cost report.

FL 9. Coinsurance Days
Required. The number of covered inpatient hospital days occurring after the 60th day and before the 9lst day or the number of covered inpatient SNF days occurring after the 20th day and before the l0lst day of the benefit period are shown for this billing period.

FL 10. Lifetime Reserve Days
Required. The provider enters the number of lifetime reserve days applicable. Change this entry, if necessary, based on data developed by your claims processing system. (See §3106.2 for special considerations in election of lifetime reserve days.)

FL 11. (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 12. Patient's Name
Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address
Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, City, State and ZIP code. A valid ZIP code is required for PRO purposes on inpatient bills.

FL 14. Patient's Birthdate
Required. The month, day, and year of birth is shown numerically as MM-DD-YYYY. If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.

FL 15. Patient Sex
Required. A "M" for male or a "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Patient's Marital Status
Not Required.

FL 17. Admission Date
Required. The month, day, and year of admission for inpatient care is shown numerically as MM-DD-YY. When using the HCFA-1450 as a hospice admission notice, the facility shows the date the beneficiary elected hospice care.

FL 18. Admission Hour
Not Required.

FL 19. Type of Admission
Required on inpatient bills only. This is the code indicating priority of this admission.

Code Structure:

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information Not Available	The hospital cannot classify the type of admission. This code is used only on rare occasions.

FL 20. Source of Admission
Required. This is the code indicating the source of this admission or outpatient registration.

Code Structure (for Emergency, Elective or Other Type of Admission):

1	Physician Referral	Inpatient: The patient was admitted upon the recommendation of a personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted upon the recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

3	HMO Referral	Inpatient: The patient was admitted upon the recommendation of a HMO physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a HMO physician.
4	Transfer from a Hospital	Inpatient: The patient was admitted as a transfer from an acute care facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5	Transfer from a SNF	Inpatient: The patient was admitted as a transfer from a SNF where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she is an inpatient.
6	Transfer from Another Facility	Inpatient: The patient was admitted to Health Care this facility as a transfer from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where he or she is an inpatient.
7	Emergency Room	Inpatient: The patient was admitted upon the recommendation of this facility's emergency room physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's emergency room physician.
8	Court/Law Enforcement	Inpatient: The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's representative.

		Outpatient: The patient was referred to this facility upon the direction of a `court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	Inpatient: The means by which the patient was admitted is not known. Outpatient: For Medicare outpatient bills this is not a valid code.
A	Transfer from a Rural Primary Care Hospital (RPCH)	Inpatient: The patient was admitted to this facility as a transfer from a RPCH where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the RPCH were he or she is an inpatient.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. (For all Part A inpatient, SNF, hospice and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an ICF
05	Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover- Christian Science Patient)
30	Still patient or expected to return for outpatient services
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
50	Hospice - home
51	Hospice - medical facility

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.

FL 23. Medical Record Number
Required. This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect processing.

Code structure (only codes affecting Medicare payment/processing are shown).

Code	Title	Definition
02	Condition is Employment Related	Code indicates patient alleges that the medical condition in this episode of care is due to environment/events resulting from employment. (See §§3415.2ff. for WC and §§3415.3ff. for BL.)
04	Patient is HMO Enrollee	Code indicates bill is submitted for information only and the Medicare beneficiary is enrolled in a risk-based HMO and the hospital expects to receive payment from the HMO.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 18 Months of Entitlement Covered By Employer Group Health Insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the first 18 months of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Code indicates the beneficiary would not provide information concerning other insurance coverage. Develop to determine the proper payer. (See §3686 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	Code indicates that in response to development questions, the patient and spouse have denied employment.

Code	Title	Definition
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Code indicates that in response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance that covers the patient.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.
15	Clean Claim Delayed in HCFA's Processing System (Payer Only Code)	Code indicates that the claim is a clean claim in which payment was delayed due to a HCFA processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See §3600.1A.3.)
16	SNF Transition Exemption (Medicare Payer Only Code)	Code indicates an exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Code indicates patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). Code indicates the patient was referred for a diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.

Code	Title	Definition
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees; or, (2) the EGHP is a multi- or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance coverage from a LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and that the employer has fewer than 100 full and part-time employees; or, (2), the LGHP is a multi- or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30		Reserved for National Assignment.
31	Patient is a Student (Full-Time - Day)	Patient declares that he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she enrolled in a coopertive/work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that he/she is enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.
ACCOMMODATIONS		
35		Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Code indicates the hospital temporarily placed the patient in a special care unit because no general care beds were available.

Code	Title	Definition
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) Code indicates that the patient was assigned to ward accommodations at his own request. This code must be supported by a written request in the provider's files. (See §3101.1F.)
38	Semi-Private Room Not Available	(Not used by hospitals under PPS.) Code indicates that the patient's assignment to a ward or private room was because there were no semi-private rooms available at admission.

NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 or 38 apply, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, pay semi-private costs.

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Code indicates patient's assignment to a private room was for medical reasons.
40	Same Day Transfer	Code indicates patient was transferred from one participating provider to another before midnight on the day of admission.
41	Partial Hospitalization	Code indicates claim is for partial hospitalization services. For outpatients this includes a variety of psychiatric programs. (See §§3112.7C and D for a description of coverage.)
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Code indicates the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
60	Operating Cost Day Outlier	(Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. Indicate the operating cost outlier portion paid in value code 17.

Code	Title	Definition
61	Operating Cost Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. Indicate the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Code indicates bill was paid under PIP. Record this from your system.
63	Payer Only Code	Code reserved for internal use only.HCFA assigns as needed. Providers do not report this code.
64	Other Than Clean Claim	(Not reported by providers.) Code indicates the claim is not "clean." Record this from your system.
65	Non-PPS Bill	(Not reported by providers.) Code indicates bill is not a PPS bill. Record this from your system for non-PPS hospital bills.
66	Provider Does Not Wish Cost Outlier Payment	Code indicates a hospital paid under PPS is not requesting additional payment as a cost outlier for this stay.
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary has elected to use LTR days when charges are less than LTR coinsurance amounts.
70	Self-Administered EPO	Code indicates the billing is for a dialysis patient who self-administers EPO.
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care In Unit	Code indicates the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where the patient and his/her helper (if necessary) were learning to perform dialysis.
74	Home	Code indicates the billing is for a patient who received dialysis services at home.
75	Home 100 percent Payment	(Not to be used for services furnished 4/16/90 or later.) Code indicates the

Code	Title	Definition
		billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100 percent program.
76	Back-up In-facility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Code indicates the provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	Code indicates this bill is for a Medicare newly covered service for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off Site	Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

Special Program Indicator Codes

Code	Title	Definition
A3	Special Federal Funding	This code is designed for uniform use by State uniform billing committees.
A5	Disability	This code is designated for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumonia/ Influenza 100% Payment	This code identifies that pneumococcal/influenza vaccine (PPV) services given that are to be paid under a special Medicare program provision.
A7	Induced Abortion-Danger to Life	Code indicates an abortion was performed to avoid danger to woman's life.
A8	Induced Abortion- Victim of Rape/Incest	Self-explanatory.
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Rural Primary Care Hospital electing to be paid an all-inclusive rate for outpatient services.

Code	Title	Definition
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or Pneumococcal Pneumonia Vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.

PRO Approval Indicator Codes

C1	Approved as Billed	Code indicates claim has been reviewed by the PRO and is fully approved including any day or cost outlier.
C3	Partial Approval	Code indicates the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41.)
C4	Admission Denied	Code indicates patient's need for inpatient services was reviewed by the PRO and none of the stay was medically necessary.
C5	Postpayment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/ Preprocedure	Code indicates that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	Code indicates the PRO authorized these services for an extended length of time, but has not reviewed the services provided.

Claim Change Reasons

Code	Title	Definition
D0	Changes to Service Dates	Self-explanatory.
D1	Changes to Charges	Self-explanatory.
D2	Changes to Revenue Codes/HCPCs	Self-explanatory.
D3	Second or Subsequent Interim PPS Bill	Self-explanatory.

Code	Title	Definition
D4	Change in GROUPER Input	Self-explanatory.
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
E0	Change in Patient Status	Self-explanatory.
M0	All-Inclusive Rate for Outpatient Services (Payer only code)	Used by a Rural Primary Care Hospital electing to be paid an all-inclusive rate for outpatient services.

FL 31. (Untitled)
Not Required. This is one of four fields which are not assigned. Use of the field, if any, is assigned by the NUBC.

FLs 32, 33, 34 and 35. Occurence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36 A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Code Structure (only codes affecting Medicare payment/processing are shown).

Code	Title	Definition
01	Auto accident	Code indicates the date of an auto accident. This code is used to report an auto accident that involves liability insurance. (See §§3419ff.)
02	No-Fault Insurance Involved - Including Auto Accident/Other	Code indicates the date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicates the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Other Accident	Code indicates the date of an accident not described by the above codes. This code is used to report that the provider has developed for other casualty related payers and has determined there are none. (Additional development not needed.)
11	Onset of Symptoms/Illness	Code indicates the date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	(HHA Claims only) Code indicates the date the patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit.
17	Date Occupational Therapy Plan Established or Reviewed	Code indicates the date a plan was established or last reviewed for occupational therapy.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A claims only.) Code indicates date on which the provider began claiming payment under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)

Code	Title	Definition
22	Date Active Care Ended	(SNF claims only.) Code indicates date on which a covered level of care ended in a SNF. Code is not required if code "21" is used.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Code indicates the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is not longer available to the patient.
26	Date SNF Bed Available	Code indicates the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care. (See §3350.)
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT. (See §3350.)
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology. (See §3350.)
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Code indicates the date of the notice provided by the hospital stating that requested car (diagnostic procedures or treatments) is not considered reasonable or necessary by Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Code indicates the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.

Code	Title	Definition
34	Date of Election of Extended Care Services	Code indicates the date the guest elected to receive extended care services (used by Christian Science Sanatoria only).
35	Date Treatment Started For Physical Therapy	Code indicates the date the billing provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge For Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay during which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
37	Date of Inpatient Hospital Discharge Non-covered Transplant Patient	Code indicates the date of discharge for inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
42	Date of Discharge	(Hospice claims only.) Code indicates date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (See §3648, FLS 32-35, code 42.) The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.
44	Date Treatment Started For Occupational Therapy	Code indicates the date the billing provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	Code indicates the date the billing provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Code indicates the date the billing provider initiated services for cardiac rehabilitation.
47-49	Payer Codes	Codes reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers do not report them.
A1	Birthdate-Insured A	Code indicates the birthdate of the insured in whose name the insurance is carried.
A2	Effective Date- Insured A Policy	Code indicates the first date the insurance is in force.
A3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer A.

B1	Birthdate- Insured B	Code indicates the birthdate of the individual in whose name the insurance is carried.
B2	Effective Date- Insured B Policy	Code indicates the first date the insurance is in force.
B3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate- Insured C	Code indicates the birthdate of the individual in whose name the insurance is carried.
C2	Effective Date- Insured C policy	Code indicates the first date the insurance is in force.
C3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for national assignment.
D0-D9		Reserved for national assignment.

FL 36. Occurrence Span Code and Dates.
Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

Code Structure (only the codes used for Medicare are shown).

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) Code indicates the dates shown are for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Nonutilizaton Dates (For Payer Use On Hospital Bills Only)	Code indicates a period of time during a PPS inlier stay for which the beneficiary had exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay From/Through dates given by the	(Part A claims only.) Code indicates Dates the patient for any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	Code indicates the actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.

Code	Title	Definition
74	Noncovered Level of Care	Code indicates the From/Through dates for a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span code 76, 77, or 79. Codes 76 and 77 apply to most noncovered care. Used for leave of absence. This code is also used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A.
75	SNF Level of Care	Code indicates the From/Through dates for a period of SNF level of care during an inpatient hospital stay. It also means that a PRO reviewing the stay approved the patient's remaining stay in the hospital because of the nonavailability of a SNF bed. For hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLS 24-30). It is not applicable to swing-bed hospitals which transfer patients from the hospital to a SNF level of care.
76	Patient Liability	Code indicates the From/Through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary. Code is to be used only where you or the PRO approve such charges in advance and the patient is notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability-- Utilization Charged	Code indicates the From/Through dates for a period of noncovered care for which the provider is liable (other than for lack of medical necessity or as custodial care.) The beneficiary's record is charged with Part A days, Part A or Part B deductible, and Part B coinsurance. The provider may collect Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) Code indicates the From/Through dates given by the patient for a SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and is not shown in FL 36. (See §3035.B.2.)

79	Provider Liability--No Utilization (Payer Code)	Code indicates the From/Through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M0	PRO/UR Stay Dates	If a code "C3" is in FLS 24-30, the "From" and "Through" dates of the approved billing period are here.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. Providers enter the control number assigned to the original bill here. Utilized by all provider types on adjustment requests (Bill Type, FL4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. (For Hospice claims only, the name, address, and provider number of a transferring Hospice is shown by the new Hospice on its HCFA-l450 admission notice. (See §3648, FL 38.) For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLS 39, 40, and 41. Value Codes and Amounts
Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "A" through line "D." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used before the second line is used and so on).

Code	Title	Definition
04	Inpatient Professional Component Charges Which are Combined Billed	Code indicates the amount shown is the sum of the inpatient professional component charges which are combined billed. Medicare uses this information in internal processes and also in the HCFA notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)

Code	Title	Definition
05	Professional Component Included in Charges and Also Billed Separately to Carrier	Code indicates the charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the bill for physician's services is processed by the carrier. These charges are also deducted when computing interim payment.
06	Medicare Part A and Part B Blood Deductible	Code indicates the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not used. When the provider gives a discount for unreplaced deductible blood, charges after the discount is applied are shown.
08	Medicare Lifetime Reserve Amount for First Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. (See §§3206 and 3211.) These are days used in the year of admission.
09	Medicare Coinsurance Amount for First Calendar Year in Billing Period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the first calendar year of the billing period times the applicable coinsurance rate. These are days used in the year of admission. (See §§3206 and 3211.) This code is not used on Part B bills.
10	Medicare Lifetime Reserve Amount for Second Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the second calendar year of the billing period times the applicable lifetime reserve rate. The code is used only for stays spanning two calendar years when lifetime reserve days were used in the year of discharge.

Code	Title	Definition
11	Medicare Coinsurance Amount for Second Calendar Year in Billing Period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. This code is used only for stays spanning two calendar years when coinsurance days were used in the year of discharge. This code is not used on Part B bills.
12	Working Aged Beneficiary/ Spouse With an EGHP	Code indicates the amount shown is the that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage. (See §3491.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	Code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD beneficiary that the provider is applying to covered Medicare charges on the bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a cond-itional payment because the EGHP has denied coverage. (See §§3490ff.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
14	No-Fault, Including Auto/Other Insurance	Code indicates the amount shown is that portion of a higher priority no-fault, including auto/other, insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the other insurance has denied coverage, or there has been a substantial delay in its payment. (See §§3419-3489.) Where the provider received no payment or a

Code	Title	Definition
		reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
15	Worker's Compensation (WC)	Code indicates the amount shown is that portion of a higher priority WC payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See §§3407-3416.4.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
16	PHS, Other Federal Agency	Code indicates the amount shown is that portion of a higher priority PHS or other Federal Agency's payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. (See §§3153ff.)
17	Operating Outlier Amount	(Not reported by providers.) Report the amount of operating outlier payment made (either cost or day) in CWF with this code. (Do not include any capital outlier payment in this entry.)
18	Operating Disproportionate Share Amount	(Not reported by providers.) Report the operating disproportionate share amount applicable with this code. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry.)
19	Operating Indirect Medical Education Amount	(Not reported by providers.) Report operating indirect medical education amount applicable with this code. Use the amount provided by the indirect medical education field in PRICER. (Do not include any PPS capital IME adjustment in this entry.)
31	Patient Liability Amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.

Code	Title	Definition
37	Pints of Blood Furnished	Code indicates the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced, is shown. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	Code indicates the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	Code indicates the total number of pints of blood which were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. (See §3235.4A.) Where the provider charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	(For inpatient service only.) Code indicates the amount shown for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Condition Codes 04 and 78 must also be reported.
41	Black Lung	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment. (See §§3415ff.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)

Code	Title	Definition
42	Veterans Affairs	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. (See §3153.1A.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
44	Amount Provider Agreed Accept From Primary Payer When this Amount is Less Than Charges But Higher than Payment Received	Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due. (See §3682.1.B.6 for an expanation.)
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, indicating that the PRO has denied all or a portion of this billing period, the number of days determined by the PRO to be covered while arrangements are made for the patient's post discharge are shown. The field contains one numeric digit.
47	Any Liability Insurance	Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. (See §§ 3419ff.) If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.
48	Hemoglobin Reading	Code indicates the latest hemoglobin reading taken during this billing cycle. This is usually reported in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Code	Title	Definition
49	Hematocrit Reading	Code indicates the latest hematocrit reading taken during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
50	Physical Therapy Visits	Code indicates the number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	Code indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	Code indicates the number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	Code indicates the number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
56	Skilled Nurse- Home Visit Hours (HHA only)	Code indicates the number of hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour.)
57	Home Health Aide- Home Visit Hours (HHA only)	Code indicates the number of hours of home health aide services provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour).

NOTE: Codes 50-57 and 60 are not money amounts but represent the number of visits. Entries for the number of visits are right justified to the left of the dollars/cents delimiter as shown.

					1	3		

Accept zero or blanks in cents position. Convert blanks to zero for CWF.

Code	Title	Definition
58	Arterial Blood Gas (PO2/PA2)	Code indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area. (See note following code 59 for an example.)
59	Oxygen Saturation (02 Sat/Oximetry)	Code indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area. (See note following this code for an example.)

NOTE: Codes 58 and 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels. Round to two decimals or to the nearest whole percent. For example, a reading of 56.5 is shown as:

							5	7

A reading of 100 percent is shown as:

						1	0	0

60	HHA Branch MSA	Code indicates MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's - Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.)
61-66		Reserved for National Assignment
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justify to the left of the dollar/cent delimiter. (Round to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Code indicates the number of units of EPO administered and/or supplied relating to the billing period and is reported in whole units to the left of the dollar/cents delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0			

70	Interest Amount	(For internal use by third party payers only.) Report the amount of interest applied to this claim.

Code	Title	Definition
71	Funding of ESRD Networks	(For internal use by third party payers only.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72	Flat Rate Surgery Charge	Code indicates the amount of the standard charge for outpatient surgery where the hospital has such a charging structure.
75	Gramm/Rudman/Hollings	(For internal use by third party payers only.) Report the amount of sequestration.
76	Provider's Interim Rate	(For internal use by third party payers only.) Report the provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. Report to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0

77-79	Payer Codes	Codes reserved for internal use only by third party payers. HCFA assigns as needed. Providers do not report payer codes.
A1	Deductible Payer A	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
B1	Deductible Payer B	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
C1	Deductible Payer C	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.

Code	Title	Definition
A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	The amount estimated by the provider to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	The amount estimated by the provider to be paid by the indicated payer.
D3	Estimated Responsibility Patient	The amount estimated by the provider to be paid by the indicated patient.
A4	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (**The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. See §3112.4.)**

FL 42. Revenue Code

Required. For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered on the adjacent line in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry in FL 47 is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48 are summed.

For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Noncovered charges are omitted from the bill.

To assist in bill review, revenue codes are listed in ascending numeric sequence to the extent possible. To limit the number of line items on each bill, revenue codes are summed at the "zero" level to the extent possible.

Providers have been instructed to provide detailed level coding for the following revenue code series:

290s - rental/purchase of DME
304 - rental and dialysis/laboratory
330s - radiology therapeutic
367 - kidney transplant
420s - therapies
520s - type of clinic visit (RHC or other)
550s-590s - home health services
624 - Investigational Device Exemption (IDE)
636 - hemophilia blood clotting factors
800s-850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

Zero level billing is encouraged for all other services. However, based upon your knowledge of a particular provider's facilities or billing practices, you may require detailed break-outs of other revenue code series. This is acceptable to the extent that it is used for bill review purposes.
See §3626.4 concerning the level of coding for outpatient surgical procedures.

001 Total Charge

01X
to
06X Reserved for National Assignment

07X
to
09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

Subcategory		Standard Abbreviations
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All-Inclusive Room and Board	ALL INCL R&B

11X Room & Board - Private (Medical or General)

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
8 - Rehabilitation	REHAB/PVT
9 - Other	OTHER/PVT

12X Room & Board - Semi-private Two Bed (Medical or General)

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
8 - Rehabilitation	REHAB/2BED
9 - Other	OTHER/2BED

13X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED
6 - Detoxification	DETOX/3&4BED
7 - Oncology	ONCOLOGY/3&4BED
8 - Rehabilitation	REHAB/3&4 BED
9 - Other	OTHER/3&4BED

14X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX
3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
8 - Rehabilitation	REHAB/DLX
9 - Other	OTHER/DLX

15X Room & Board Ward
(Medical or General)

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
8 - Rehabilitation	REHAB/WARD
9 - Other	OTHER/WARD

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under state regulations or other statutes supersede the following guidelines. For example, some states may have fewer than four levels of care or may have multiple levels within a category such as intensive care.

Level I - Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).
Level II - Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (Continuing Care).
Level III - Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).
Level IV - Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn - Level I	NURSERY/LEVEL I

Subcategory	Standard Abbreviation
2 - Newborn - Level II	NURSERY/LEVELII
3 - Newborn - Level III	NURSERY/LEVELIII
4 - Newborn - Level IV	NURSERY/LEVELIV
9 - Other	NURSERY/OTHER

18X Leave of Absence

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

NOTE: Charges are billable for codes 2 - 5

0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

19X Subacute Care

Accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Level I - Skilled Care: Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II - Comprehensive Care: Moderate to extensive nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III - Complex Care: Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV - Intensive Care: Extensive nursing and technical intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

Subcategory	Standard Abbreviation
0 - General Classification	SUBACUTE
1 - Subacute Care - Level I	SUBACUTE/LEVEL I
2 - Subacute Care - Level II	SUBACUTE/LEVEL II
3 - Subacute Care - Level III	SUBACUTE/LEVEL III
4 - Subacute Care - Level IV	SUBACUTE/LEVEL IV
9 - Other Subacute Care	SUBACUTE/OTHER

20X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are identified.

Subcategory	Standard Abbreviation
0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - Intermediate ICU	ICU/INTERMEDIATE
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for furnishing such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0 - General Classification	CORONARY CARE or (CCU)
1 - Myocardial Infarction	CCU/MYO INFARC
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - Intermediate CCU	CCU/INTERMEDIATE
9 - Other Coronary Care	CCU/OTHER

ANCILLARY REVENUE CODES (22X - 99X)

22X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services furnished in greater detail and break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

23X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

24X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0 - General Classification	ALL INCL ANCIL
9 - Other Inclusive Ancillary	ALL INCL ANCIL/OTHER

25X Pharmacy

Code indicates the charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements. Subcode 4 is for providers that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Subcode 5 is for providers that do not bill for drugs used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Nongeneric Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X IV Therapy

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem rate.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY
1 - Infusion Pump	IV THER/INFSN PUMP
2 - IV Therapy/Pharmacy Services	IV THER/PHARM/SVC
3 - IV Therapy/Drug/Supply/Delivery	IV THER/DRUG/SUPPLY DELV
4 - IV Therapy/Supplies	IV THER/SUPPLIES
9 - Other IV Therapy	IV THERAPY/OTHER

27X Medical/Surgical Supplies. (Also see 62X, an extension of 27X.)

Code indicates the charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

28X Oncology

Code indicates the charges for treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

29X Durable Medical Equipment (DME) (Other Than Renal)

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Nonroutine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMATOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

31X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
1 - Angiocardiography	DX X-RAY/ANGIO
2 - Arthrography	DX X-RAY/ARTH
3 - Arteriography	DX X-RAY/ARTER
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of the State of Ohio.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service furnished.

Subcategory	Standard Abbreviation
0 - General Classification	NUCLEAR MEDICINE or (NUC MED)
1 - Diagnostic	NUC MED/DX
2 - Therapeutic	NUC MED/RX
9 - Other	NUC MED/OTHER

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	CT SCAN
1 - Head Scan	CT SCAN/HEAD
2 - Body Scan	CT SCAN/BODY
9 - Other CT Scans	CT SCAN/OTHER

36X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

37X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including Medicare. Subcode 1 is for providers that do not bill anesthesia used for other diagnostic services as part of the charge for the diagnostic service. Subcode 2 is for providers that do not bill anesthesia used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	Standard Abbreviation
0 - General Classification	ANESTHESIA
1 - Anesthesia Incident to RAD	ANESTHE/INCIDENT RAD
2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCIDENT ODX
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

38X Blood

Rationale: Charges for blood must be separately identified for private payers purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PALTELETES
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives (Cryopricipitates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

40X Other Imaging Services

Subcategory	Standard Abbreviation
0 - General Classification	IMAGE SERVICE
1 - Diagnostic Mammography	MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
3 - Screening Mammography	SCR MAMMOGRAPHY/GEN MAMMO
4 - Positron Emission Tomography	PET SCAN
9 - Other Imaging Services	OTHER IMAG SVS

NOTE: Medicare will require the hospitals to report the ICD-9 diagnosis codes (FL 67) to substantiate those beneficiaries considered high risks. These high risk codes are as follows:

ICD-9 Codes	Definitions	High Risk Indicator
V10.3	Personal History- Malignant neoplasm breast cancer	A personal history of breast cancer
V16.3	Family History- Malignant neoplasm breast cancer	A mother, sister, or daughter who has had breast cancer
V15.89	Other specified personal history representing hazards to health	Not given birth prior to 30 or a personal history of biopsy-proven benign breast disease

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

43X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual’s level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosethic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

45X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers. Under the provisions of EMTALA (Emergency Medical Treatment and Active Labor Act), a hospital with an emergency department must provide upon request and within the capabilities of the hospital an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

Subcategory	Standard Abbreviation
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical screening services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 - Urgent Care	URGENT CARE
9 - Other Emergency Room	OTHER EMER ROOM

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Observation Room."

Usage Notes
An "X" in the matrix below indicates an acceptable coding combination.

	450 (a)	451 (b)	452 (c)	456	459
450					
451			X	X	X
452			X		
456			X		X
459			X		X

(a) General Classification code 450 should not be used in conjunction with any subcategory. The sum of codes 451 and 452 is equivalent to code 450. Payers that do not require a breakdown should roll up codes 451 and 452 into code 450.

(b) Stand alone usage of code 451 is acceptable when no services beyond an initial screening/assessment are rendered.

(c) Stand alone usage of code 452 is not acceptable.

46X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviation
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

48X Cardiology

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
3 - Echocardiology	ECHOCARDIOLOGY
9 - Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Observation Room."

50X Outpatient Services

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This revenue code is no longer used for Medicare.

Subcategory	Standard Abbreviation
0 - General Classification	OUTPATIENT SVS
9 - Other Outpatient Services	OUTPATIENT/OTHER

51X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
3 - Psychiatric Clinic	PSYCH CLINIC
4 - OB-GYN Clinic	OB-GYN CLINIC
5 - Pediatric Clinic	PEDS CLINIC
6 - Urgent Care Clinic	URGENT CLINIC
7 - Family Practice Clinic	FAMILY CLINIC
9 - Other Clinic	OTHER CLINIC

52X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice Clinic	FR/STD FAMILY CLINIC
6 - Urgent Care Clinic	FR/STD URGENT CLINIC
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: This is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviations
0 - General Classification	OSTEOPATH SVS
1 - Osteopathic Therapy	OSTEOPATH RX
9 - Other Osteopathic Services	OTHER OSTEOPATH

54X Ambulance

Charges for ambulance service usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 - General Classification	AMBULANCE
1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/0XY
5 - Air Ambulance	AIR AMBULANCE
6 - Neo-natal Ambulance	AMBUL/NEO-NATAL
7 - Pharmacy	AMBUL/PHARMACY
8 - Telephone Transmission EKG	AMBUL/TELEPHONIC EKG
9 - Other Ambulance	OTHER AMBULANCE

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Code indicates the charges by an HHA for visits other than physical therapy, occupational therapy, or speech therapy, which must be specifically identified.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

59X Units of Service (Home Health)

This revenue code is used by an HHA that bills on the basis of units of service.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

60X Oxygen (Home Health)

Code indicates the charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292, or 293.

Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
3 - Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON

61X MRI

Code indicates charges for Magnetic Resonance Imaging (MRI) of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	MRI
1 - Brain (including Brainstem)	MRI - BRAIN
2 - Spinal Cord (including Spine)	MRI - SPINE
9 - Other MRI	MRI - OTHER

62X Medical/Surgical Supplies - Extension of 27X

Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that do not bill supplies used under radiology revenue codes as part of the radiology procedure charges. Subcode 2 for radiology is for providers that do not bill supplies used for other diagnostic services as part of the charge for services in the diagnostic service.

Subcategory	Standard Abbreviation
1 - Supplies Incident to Radiology	MED-SUR SUPP/INCIDNT RAD
2 - Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCIDNT ODX
3 - Surgical Dressings	SURG DRESSING
4 - Investigational Device	IDE

63X Drugs Requiring Specific Identification

Code indicates charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in FL 44.

Subcategory	Standard Abbreviation
0 - General Classification	DRUGS
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythroepoetin (EPO) less than 10,000 units	DRUG/EPO/≤10,000 units
5 - Erythroepoetin (EPO) 10,000 or more units	DRUG/EPO/≥10,000 units
6 - Drugs Requiring Detailed Coding*	DRUGS/DETAIL CODE
7 - Self-administrable Drugs	DRUGS/SELFADMIN

NOTE: *Revenue code 636 relates to HCPCS code, so HCPCS is the recommended code to be used in FL 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

NOTE: Value code A4 used in conjunction with Revenue Code 637 indicates the amount included for covered charges for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. This is the only ordinarily non-covered, self-administered drug covered under Medicare with this value code.

64X Home IV Therapy Services

Charge for intravenous drug therapy services which are performed in the patient's residence. For home IV providers, the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY SVC
1 - Nonroutine Nursing	NON RT NURSING/CENTRAL
2 - IV Site Care, Central Line	IV SITE CARE/CENTRAL
3 - IV Start/Change Peripheral Line	IV STRT/CHNG/PERIPHAL
4 - Nonroutine Nursing, Peripheral Line	NONRT NURSING/PERIPHRL
5 - Training Patient/Caregiver, Central Line	TRNG/PT/CARGVR/CENTRAL
6 - Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL

7 - Training Patient/Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL
8 - Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
9 - Other IV Therapy Services	OTHER IV THERAPY SVC

NOTE: Units need to be reported in 1 hour increments. Revenue code 642 relates to the HCPCS code.

65X Hospice Services

Code indicates the charges for hospice care services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care - ½	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (nonrespite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
9 - Other Hospice	HOSPICE/OTHER

66X Respite Care (HHA only)

Charges for hours of care under the respite care benefit for services of a homemaker or home health aide, personal care services, and nursing care provided by a license professional nurse.

Subcategory	Standard Abbreviation
0 - General Classification	RESPITE CARE
1 - Hourly Charge/Skilled Nursing	RESPITE/SKILLED NURSE
2 - Hourly Charge/Home Health Aide/ Homemaker	RESPITE/HMEAID/HMEMKE

67X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	Standard Abbreviation
0 - General Classification	OP SPEC RES
1 - Hospital Based	OP SPEC RES/HOSP BASED
2 - Contracted	OP SPEC RES/CONTRACTED
9 - Other Special Residence Charges	OP SPEC RES/OTHER

68X Not Assigned

69X Not Assigned

70X Cast Room

Charges for services related to the application, maintenance, and removal of casts.

Rationale: Permits identification of this service, if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	CAST ROOM
9 - Other Cast Room	OTHER CAST ROOM

71X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

74X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviation
0 - General Classification	GASTR-INTS SVS
9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

76X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 762 should be used for observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. The reason for observation must be stated in the orders for observation. Payer should establish written guidelines which identify coverage of observation services.

Subcategory	Standard Abbreviation
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM
2 - Observation Room	OBSERVATION RM
9 - Other Treatment Room	OTHER TREATMENT RM

77X Preventative Care Services

Charges for the administration of vaccines.

Subcategory	Standard Abbreviation
0 - General Classification	PREVENT CARE SVS
1 - Vaccine Administration	VACCINE ADMIN
9 - Other	OTHER PREVENT

78X Telemedicine

Future use to be announced - Medicare Demonstration Project.

Subcategory	Standard Abbreviation
0 - General Classification	TELEMEDICINE
9 - Other Telemedicine	TELEMEDICINE/OTHER

79X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abbreviation
0 - General Classification	LITHOTRIPSY
9 - Other Lithotripsy	LITHOTRIPSY/OTHER

80X Inpatient Renal Dialysis

A waste removal process, performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

81X Organ Acquisition

The acquisition and storage of various organs used for transplantation.

Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.

Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	ORGAN ACQUISIT
1 - Living Donor	LIVING/DONOR
2 - Cadaver Donor	CADAVER/DONOR
3 - Unknown Donor	UNKNOWN/DONOR
4 - Unsuccessful Organ Search Donor Bank Charge*	UNSUCCESSFUL SEARCH
9 - Other Organ Donor	OTHER/DONOR

NOTE: Revenue code 814 is used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

83X Peritoneal Dialysis - Outpatient or Home

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 - Other Peritoneal Dialysis	PERTNL/HOME/OTHER

84X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintanence 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 - Other CAPD Dialysis	CAPD/HOME/OTHER

85X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintanence 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other CCPD Dialysis	CCPD/HOME/OTHER

86X Reserved for Dialysis (National Assignment)

87X Reserved for Dialysis (State Assignment)

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultrafiltration	DIALY/ULTRAFILT
2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
9 - Misc. Dialysis Other	DIALY/MISC/OTHER

89X Reserved for National Assignment

90X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
4 - Activity Therapy	ACTIVITY THERAPY
9 - Other	OTHER PSTAY RX

91X Psychiatric/Psychological Services

Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment.

Rationale: This breakdown provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PSYCH/SERVICES
1 - Rehabilitation	PSYCH/REHAB
2 - Partial Hospitalization* - Less Intensive	PSYCH/PARTIAL HOSP
3 - Partial Hospitalization - Intensive	PSYCH/PARTIAL INTENSIVE
4 - Individual Therapy	PSYCH/INDIV RX
5 - Group Therapy	PSYCH/GROUP RX
6 - Family Therapy	PSYCH/FAMILY RX
7 - Bio Feedback	PSYCH/BIOFEED
8 - Testing	PSYCH/TESTING
9 - Other	PSYCH/OTHER

NOTE: Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.

92X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

93X Not Assigned

94X Other Therapeutic Services

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Complex Medical Equipment Routine	RTN COMPLX MED EQUIP
7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP
9 - Other Therapeutic Services	ADDITIONAL RX SVS

95X Not Assigned

96X Professional Fees

Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSTAY
2 - Ophthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

97X Professional Fees

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

98X Professional Fees

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers as strictly convenience items and are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

FL 43. Revenue Description
Not Required. A narrative description or standard abbreviation for each revenue code in FL 42 is shown on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: **FDA IDE # A123456 (17 spaces).**

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS (i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, radiology, other diagnostic services, orthotic prosthetic devices), the provider enters the HCPCS code describing the procedure here.

On inpatient hospital or SNF bills, the accommodation rate is shown here.

Effective April 1, 1995, a line item date of service is required on all laboratory claims that span 2 or more dates.

FL 45. Service Date
Not Required. For outpatient claim providers, report a separate date for each day of service.

FL 46. Service Units
Required. The entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. Providers have been instructed to provide the number of covered days, visits, treatments, and tests applicable for the following:

Accommodations - 100s-150s, 200s, 210s (days)
Blood - 380s (pints)
DME - 290s (rental months)
Emergency room visits - 450 (visits)
Clinic visits - 510s and 520s (visits)
Dialysis treatments - 800s (sessions or days)
Orthotic/prosthetic devices - 274 (items)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (visits)
Outpatient clinical diagnostic laboratory tests - 30s-31s (tests)
Radiology - 32X, 34X, 35X, 40X, 61X, and 333 (tests or services)
Oxygen - 600s (rental months, feet or pounds)
Hemophilia blood clotting factors - 636

Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.

NOTE: Have hospital outpatient departments and community mental health centers report the number of visits/sessions when billing under the partial hospitalization program. (See §§3651 and 3661 for more detailed information for reporting of service units.)

FL 47. Total Charges
Required. The total charges for the billing period are summed by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and entered on the adjacent line in FL 47. The last revenue code entered in FL 42 is "0001" which represents the grand total of all covered and non-covered charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional component is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Non-covered charges are omitted from the bill.

Laboratory tests (revenue codes 300-319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. Determine, in consultation with the provider, whether it must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, adjust interim payment rates to exclude payment for hospital-based physician services.

The physician component must be billed to the carrier to obtain payment.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled)
Not Required. This is one of the four fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLS 50A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered, the provider has developed for other insurance and has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on lines B or C, as appropriate. (See §§3407-3415, §§3419, and §§3489-3492 to determine when Medicare is not the primary payer.)

FLs 51A, B, and C. Provider Number
Required. This is the six-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C. Release of Information
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

NOTE: The back of the HCFA-1450 contains a certification that all necessary release statements are on file.

FLs 54A, B, and C. Prior Payments
Required. For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.

Part A home health DME cost sharing amounts collected from the patient are reported in this item. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as noncovered by Medicare. Thus, for example, if total inpatient hospital charges are $350 including $50 for a deductible pint of blood, $300 is to be apportioned to the Part A deductible and $50 to the blood deductible. Blood is treated the same way in both Part A and Part B.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56 (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 57. (Untitled)
Not Required. This is one of the seven fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in §§3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and their spouses. (See §3491.);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to l8 months. (See §3490.);
- LGHPs for disabled beneficiaries;
- Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490.);
  or
- WC, including BL. (See §§3407-3416.)

FLs 59A, B, and C. Patient's Relationship to Insured
Required. If the provider is claiming a payment under any of the circumstances described in the second paragraph of FLs 58A, B, or C, it may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured has Financial Responsibility	Self-explanatory
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.

Code	Title	Definition
09	Unknown	Patient's relationship to the insured is unknown.
11	Organ Donor	Code is used in cases where a bill is submitted for care given to an organ donor where it is paid by the receiving patient's insurance coverage.
12	Cadaver Donor	Code is used where a bill is submitted for procedures performed on a cadaver donor where they are paid by the receiving patient's insurance coverage.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. The provider enters the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, EOMB, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the SSO. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's HICN, i.e., if Medicare is the primary payer, this information is entered in FL 60A.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP coverage for the patient or the spouse or during the first year of ESRD entitlement), the involved claim number for that coverage is shown on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the name of the insurance group or plan.

FLs 62A, B, and C. Insurance Group Number
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the identification number, control number, or code assigned by such health insurance carrier.

FL 63. Treatment Authorization Code
Required. Whenever PRO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, the authorization number is required for all approved admissions or services.

FL 64. Employment Status Code
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the code which defines the employment status of the individual identified on the same line in FL 58, if the information is readily available.

Code	Title	Definition
1	Employed Full-Time	Individual stated that he or she is employed full-time
2	Employed Part-Time	Individual stated that he or she is employed part-time
3	Not Employed	Individual states that he or she is not employed full-time or part time
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for National Assignment
9	Unknown	Individual's Employment Status is unknown

FL 65. Employer Name
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66. Employer Location
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, and there is WC involvement or an EGHP, it enters the specific location of the employer of the individual identified on the same line in FL 58. A specific location is the city, plant, etc., in which the employer is located.

FL 67. Principal Diagnosis Code
HCFA only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in DHHS Publication No. (PHS) 89-l260 or HCFA approved errata and supplements to this publication. HCFA approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Inpatient--Required. The provider reports the principal diagnosis in this field. The principal diagnosis is the condition established after study to be chiefly responsible for this admission.

Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

Outpatient--Required. Hospitals report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. Hospitals report the diagnosis to their highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0).

If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- Examination of ears and hearing (V72.1).

NOTE: Diagnosis codes are not required on nonpatient claims for laboratory services where a hospital is functioning as an independent laboratory. (See §3628.)

FLs 68-75. Other Diagnoses Codes
Inpatient--Required. The provider reports the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis entered in FL 67 should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, eliminate it before GROUPER. Proper installation of MCE identifies situations where the principal diagnosis is duplicated.

Outpatient--Required. Hospitals report the full ICD-9-CM codes in FLs 68-75 for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67. For instance, if the patient is referred to the hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported here.

FL 76. Admitting Diagnosis
Required. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. (See §3770.1.) Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 77. E-Code
Not Required.

FL 78. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 79. Procedure Coding Method
Not Required.

FL 80. Principal Procedure Code and Date
Required for Inpatient Only. The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (FL 67). See §3626.4 for reporting outpatient procedures.

For this item, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation. Review this item against FLs 42-47. It may alert you to noncovered services or omissions.

The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all four digit codes where applicable. See first paragraph under FL 67 for acceptable ICD-9-CM codes.

The date applicable to the principal procedure is shown numerically as MM-DD-YY in the "date" portion.

Transmit to HCFA the original codes reported by the provider. If in the course of the claims development process you determine the codes are incorrect, transmit the corrected codes.

Pacemaker related ICD-9-CM procedure codes (37.70 and 37.73-37.85) require you to follow special procedures. (See §3678.)

FL 81. Other Procedure Codes and Dates
Required for Inpatient Only. The full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 80). The date of each procedure is shown in the date portion of Item 81, as applicable, numerically as MM-DD-YY.

Transmit to HCFA the original codes reported by the provider. If in the course of the claims development process you determine the codes are incorrect, transmit the corrected codes.

Pacemaker related ICD-9-CM procedure codes (37.70 and 37.73-37.85) require you to follow special procedures. (See §3678.)

FL 82. Attending/Referring Physician ID
Required. Effective January 1, 1992, providers must enter the unique physician identification number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services. Paper bill specifications are listed below. See Addendum A, record type 80 for electronic tape specifications. Accept data on paper bills that does not strictly adhere to the following, i.e., commas instead of spaces between subfields, or other minor variances if you can process it at no extra cost.

Inpatient Part A.--Hospitals and SNFs must enter the UPIN and name of the attending/referring physician. For hospital services, the Uniform Hospital Discharge Data Set definition for attending physician is used. This is the clinician primarily responsible for the care of the patient from the beginning of the hospital episode. For SNF services, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Home Health and Hospice.--HHAs and hospices must enter the UPIN and name of the physician that signs the home health or hospice plan of care. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Outpatient and Other Part B.--All providers must enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial. If the patient is self-referred (e.g., emergency room or clinic visit), SLF000 is entered in the first six positions, and no name is shown.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs, or Public Health Services. Providers must use the following UPINs to report these physicians:

- INT000 for each intern
- RES000 for each resident
- PHS000 for Public Health Service physicians, includes Indian Health Services
- VAD000 for Department of Veterans Affairs physicians
- RET000 for retired physicians
- SLF000 for providers to report that the patient is self-referred
- OTH000 for all other unspecified entities not included above

Accept the SLF entry unless the revenue code or HCPCS code indicates the service can be provided only as a result of physician referral. Accumulate and analyze information on providers that report SLF or OTH. Investigate the five provider types that report the highest percentage of SLF or OTH from January 1, 1992-June 30, 1992. Report your findings on the validity of their use of SLF and OTH to the RO.

If more than one referring physician is involved, the provider enters the UPIN of the physician requesting the service with the highest charge.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

FL 83. Other Physician ID.

Inpatient Part A Hospital.--Required if a procedure is performed. Hospitals must enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure, the hospital enters the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, the hospital leaves this item blank. See FL 82 (inpatient) for specifications.

Outpatient Hospital.--Required where the HCPCS code reported is subject to the Ambulatory Surgical Center (ASC) payment limitation or a reported HCPCS code is on the list of codes the PRO furnishes that require approval. Hospitals enter the UPIN and name of the operating physician. They use the format for inpatient reporting.

Other Bills
Not Required.

FL 84. Remarks
Required. For DME billings by HHAs, the rental rate, cost and anticipated months of usage are shown so that you may determine whether to approve the rental or purchase of equipment. In addition, special annotations may be entered where Medicare is not the primary payer because WC, an automobile medical or no-fault insurer, any liability insurer or an EGHP/LGHP is primary to Medicare. (See §§3679, 3680, 3681, and 3682.)

This space is also available to report overflow from other items.

FL 85. Provider Representative Signature.
Not Required. No signature is required for a general care hospital unless a certification is required. (See §3315.2.) A provider representative's signature or facsimile is required on the bill of a psychiatric or tuberculosis hospital.

FL 86. Date
Not Required. This is the date of the provider representative's signature.